OFFICE OF THE DISTRICT ATTORNEY - 18TH JUDICIAL DISTRICT

REQUEST FOR RESTITUTION — MEDICAL

DEFENDANT/OFFENDER'S NAME _____ **CASE NO.** _____

IF YOU FEEL THAT RESTITUTION IS NOT OWED TO YOU, OR YOU DO NOT WISH TO FILE FOR RESTITUTION NOW OR IN THE FUTURE, PLEASE CHECK THIS BOX ☐ **. SIGN AND DATE AT THE BOTTOM OF THIS PAGE, AND MAIL THIS FORM BACK TO US.** **PLEASE TYPE OR PRINT CLEARLY WITH BALL POINT PEN.**

COMPLETE VICTIM INFORMATION WHERE APPLICABLE

VICTIM _____ DATE OF BIRTH _____ SEX: M ___ F ___ RACE _____

ADDRESS: _____ SSN: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ WORK: _____ OTHER: _____ FAX: _____

IF VICTIM IS A MINOR, LIST NAME OF PARENT OR GUARDIAN:

NAME _____ RELATIONSHIP _____

SSN _____ DATE OF BIRTH _____ SEX: M ___ F ___ RACE _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ WORK: _____ OTHER: _____ FAX: _____

MEDICAL INSURANCE INFORMATION

INCLUDE PERSONAL, WORK OR GOVERNMENT ASSISTANCE PROGRAMS.

WILL A CLAIM BE FILED WITH ANY INSURANCE COMPANY OR GOVERNMENT PUBLIC ASSISTANCE PROGRAM (SRS - MEDICAL CARD, MEDICAID, MEDICARE, ETC.,)? ☐ Yes ☐ No

IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURANCE COMPANY OR GOVERNMENT PROGRAM _____

ADDRESS: _____ PHONE: _____

CITY _____ STATE _____ ZIP _____

POLICY NO. _____ CLAIM NO. _____

DEDUCTIBLE $ _____ IF KNOWN, AMOUNT INSURANCE WILL PAY $ _____

PERSONAL INJURY OR DEATH

IF THE VICTIM SUFFERED PERSONAL INJURY OR DEATH, PLEASE COMPLETE THE ENCLOSED "CRIME VICTIM COMPENSATION" APPLICATION FORM, AND MAIL IT TO THE TOPEKA ADDRESS ON THAT FORM FOR PROCESSING.

Print Your Name _____

Your Signature _____ Date _____

PS-1148

RETURN THE YELLOW & GREEN COPIES TO THE OFFICE OF THE DISTRICT ATTORNEY.
KEEP THE WHITE COPY FOR YOUR RECORDS.